



Questions? Call 1-800-977-0351

RETURN THIS COPY

Please complete **BOTH PAGES** of this Assignment of Benefits form.

1. Mail to: NationsHealth
P.O. Box 267970
Weston, FL 33326-9895
OR
2. Fax to: 1-800-977-0601

Assignment of Benefits – Sign, date and return this form immediately.

In order for United States Pharmaceutical Group d/b/a NationsHealth to bill Medicare and/or other insurance for your medical supplies and/or medications, this form must be completed, signed, dated and returned immediately.

Without the signed and dated form on file, we cannot continue to send you the products you ordered.

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to NationsHealth for medication(s) and medical equipment furnished to me by NationsHealth and/or any of their corporate affiliates.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns, as needed for the limited purpose of processing payments, treatment or NationsHealth operations.
4. NationsHealth and/or any of their corporate affiliates to obtain medical or other or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments and deductibles.
6. NationsHealth and/or any of their corporate affiliates to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

Your Phone # (____) _____

SIGN HERE **TODAY'S DATE**

YOUR MEDICARE # - - -

Patient ID: _____

Patient Name _____
Street Address _____

City _____ State _____ Zip _____

Secondary Insurer _____
 (other than or in addition to Medicare)
 Insurer Phone # (____) _____
 Policy # _____ Group # _____
 Plan # _____
 Name of Insured _____
 Relation to Insured _____



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Please provide additional information to help NationsHealth serve you.

Alternate Contact

If you are not available, whom else can we contact to help with your supplies?

Alternate Contact Name _____

Relation to the Member _____ Phone # (____) _____

Physician's Information

Your Physician's Name _____

Your Physician's Phone # (____) _____ Fax # (____) _____

Your Physician's Office Address _____

City _____ State _____ Zip _____

Please correct any errors in your name or address

Name _____

Address _____

Complete the FRONT AND BACK of this form. Call 1-800-977-0351 with any questions.